MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH
County Nodaway Registration District No. 6 20 File No. 25732
Township Jefferson Primary Registration District No. 5822 Registered No.
City Conception (No. , St. , Ward)

2. FULL NAME James Donald Mc Cann

(a) Residence No. (Usual place of abode) St., Ward. (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 13 yrs. 9 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Single

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 9-29 1920

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	13	9	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Conception Jct
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER Eugene Mc Cann
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Conception Jct
(STATE OR COUNTRY) Mo
12. MAIDEN NAME OF MOTHER Cora Schiefelbusch
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Forest
(STATE OR COUNTRY) Mo

14. INFORMANT Eugene Mc Cann
(Address) Clyde Mo

15. FILED Aug 1, 19 34 Mabel Graham
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7 - 23 1934

17. I HEREBY CERTIFY, That I attended deceased from July 21, 1934, to July 22, 1934, that I last saw h. alive on July 21, 1934, and that death occurred, on the date stated above, at 5 15 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (SECONDARY) Epilepsy under development

(duration) 11 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) J M Bayless, M. D.

, 19 (Address) Conception Junct

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Conception Jct Mo	7-24 1934
20. UNDERTAKER J R. Pruett	ADDRESS Conception Jct Mo

AUG 20 1934

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

#2

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

WASHINGTON

E. T. McGaugh, M. D.,
Special Agent,
Jefferson City, Mo.

Nodaway

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: James Donald McCann

Who died at Conception Mo on July 23 - 1934

Residence: No. _____ St. _____

(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex M Color or race W Single, ~~married, widowed or divorced~~: _____

Date of birth 9-29-1920 Age: Years 13 Months 9 Days 24

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____

(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

Date deceased last worked at this occupation: Month _____ Year _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

Principal cause of death: Pneumonia 10 6

X Lobar

Epilepsy - under developed.

Other contributory causes of importance _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____

(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

Name of physician Dr J M Bayless Conception Jct Mo

Address of physician Mabel M Cunningham

X Signature of Registrar X Date filed Aug 8 1934

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,

E. T. McGaugh M D
S. C

Special Agent.

Reg. Dist. No. 620

Primary Reg. Dist. No. 5822

S-25732